Pediatric Spinal Cord Injury Clinical Pathway

Holland Bloorview Kids Rehabilitation Hospital

No boundaries

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Pediatric Rehabilitation Spinal Cord Injury (SCI) Clinical Pathway

Pre-admission	Day 1: Admission	Week 1: Assessment and planning	Week 2-8: Therapy to get your child started	Week 8-16: Therapy to get your child mobile	Week 16-24: Therapy to get your child home
• Orientation to spinal cord services and in-patient rehab Program • Medical intake meeting • Connect with care team • Review consent process	• Meet the rehab team • Orientation to SCI scheduling routines • Medical & Nursing full needs & safety assessment • Equipment review • Receive Transition Passport with educational materials • School registration	• Initial Family team goal plan meeting • Identification of short and long term goals & priorities for rehab • Identify client and family SCI educational needs • Initial discussion on transition plan with target discharge date & Planning for weekend pass • Full Needs Assessment with rehab team & Physiatrist consultation • Attendance at school begins • Establish and implement SCI protocols and education sessions	• Second Family team goal plan meeting • Review of prognosis, goal achievement, functional outcomes and care Requirements • Begin SCI curriculum • Engage in rehab therapy program • Begin care by parent sessions • Initiating weekend pass • Access to peer support • Identification of transition needs • Appropriate amendments to action plan. • Liaison with relevant outpatient social & community services	• Third Family team goal plan meeting • Review of goal achievement Functional outcomes and care requirements. • Continue SCI curriculum • Confirmation of transition location, care package • Identification of carer and Community team training needs. • Introduction to SCI outpatient team • NP/RN-attendance at Family team goal plan meeting	• In-patient rehab goals achieved • Recommendations for Ongoing Outpatient rehab shared with outpatient therapy teams at transition family team meeting. • Client medically stable for transition • Client, family & carer education completed. • Client proficient in self monitoring & • Engaged in health maintenance. • Equipment in place, discharge location and care provision safe and sustainable.

Clients Needs and Overview of Key Components of Clinical Pathway

	Pre-admission	Day 1: Admission	Week 1: Assessment and planning	Week 2-8: Therapy to get your child started	Week 8-16: Therapy to get your child mobile	Week 16-24: Therapy to get your child home
Psychosocial wellbeing/ safety	Psychosocial Screen Identify red flags Social worker (SW) & Child Life specialist (CLS) handover Case Conference meeting	Safety Assessment Meet Social worker (SW) Child Life specialist (CLS), *Psychologist,* Therapeutic recreation specialist (TR)	Detailed Psychosocial assessment Creation of safety plan Behavioral interventions Introduction to the "All about me" tool and guidance completing	Individualized sessions with client Child Life specialist (CLS) Psychologist/Psychiatry Individualized sessions with parents/clients (SW) Review of Financial resources & applications (SW)	Identify Needs and Refer for counselling to community resources eg. EKO, private counselling, etc. Prepare handover	Collaborate with community providers and support transition to community
Physical wellbeing/ Safety	Handover Tool Review of prognosis Primary Care provider (PCP) call Nursing 24 hour pre-admit call MD/NP→MD/NP	Full medical and physical assessment (MD/NP, & Nursing) Physical Safety assessment. Meet PT, OT, RT, Pharmacy, Dietician	Physiatrist Assessment & therapy plan Respirologist Assessment (PRN) Rehab assessment Establish care Protocols	Review of prognosis, update primary care MD/NP Review Bowel & Bladder, pain, DVT, meds, Skin, Autonomic Dysreflexia (AD), dental Begin physical therapy program *Coordination of specialist appointments & communication with specialists*	Review and adjust care protocols PRN. eg bowel. bladder, Pain, AD, OH, DVT, Skin Review and adjust Therapy goals as needed monthly Ongoing specialist collaboration	Connect with PCP for transition home Ensure referrals & follow-up with SCI clinic are arranged
Community /Transition	Discuss Discharge Location Screen Financial needs Consulting personal Injury lawyer		First Family team goal planning meeting Meet the Transition Coordinator **Refer to Outpatient SCI program @ EKO** **If Incomplete SCI injury (client will receive therapy up to 3 times/week x 1 yr post discharge)**	Identify potential discharge delays & interim d/c location requirements OT home assessment- referral to Local Health Integrated Network (LHIN)	Confirm discharge location. Provide family with list of Supplies/equipment/source costing Introduction to SCI outpatient team- NP/Nursing-attendance at last Family team goal plan meeting	Community reps/therapists from EKO to attend transition family team meeting
SCI Curriculum	Transition passport given to family on site visit/tour available Online/website	Orientation & tour to unit and daily schedule	Car transfers and Equipment Begin structured education sessions personalized to level of injury with big focus on skills acquisition. (Written, F2F, and online)	Establish and incorporate play therapy into education sessions if client <10 yrs/age	Perform teach back methodology for client and family Support discharge summary writing	Reinforce education daily Ensure family have adequate resources, online, written before discharge
Social Integration/ Recreational/ School	Transition Passport	School registration Consent for Therapeutic Recreation	Attendance at school Begin weekend LOA's Therapeutic Recreation attendance Music & Art therapy referral	Liaison with relevant social services EKO, LHIN, School Ongoing LOA's & TR participation	Arrange community School visit	Community School reps to attend transition family team meeting
OUTCOMES						
Clinical		ASIA	ASIA, COPM,	FNQ-PR	ASIA, COPM	ASIA, COPM
DATA PROCESS						